ACCIDENT QUESTIONNAIRE

Date____
Injured Party (Patient Name)___________________________________
Date of Accident_______________________________

In order to update our records and complete claims processing we are asking that you complete this questionnaire concerning your injuries. Thank you for assisting our efforts in providing quality service.

Briefly describe the cause of injury: (e.g., location of accident/how it happened)
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Name of your Insurance Company (e.g. auto, homeowners, workers comp, NOT medical)
Insurance Company Address____
(Street) (City) (State) (Zip)

Policy Holder Name ____
Policy # ______________________________________ Claim # _________________________________

If you have retained an attorney, please provide the following information:
Attorney Name ____
Address ____
(Street) (City) (State) (Zip)
Phone Number _____(________)____________________________________

Name of other party who may be responsible for the injuries:
Name___________________________________ Phone Number _(______)________________________
Address ____
(Street) (City) (State) (Zip)

Name of Insurance Company________________________ Phone Number _(_____)_________________
Insurance Company Address____
(Street) (City) (State) (Zip)

Policyholder Name_________________________________ Policy Number________________________
Adjuster Name____________________________________ Claim Number_________________________

Signature____ Date____________________